La Crosse County
Human Services Department
300 North Fourth Street
P.O. Box 4002
La Crosse, WI 54602-4002

CONSENT FOR MEDICAL TREATMENT

Western Region Adolescent Services

I, _____as the parent /guardian/custodian
(name)

of _____hereby authorize the La Crosse County
(name of juvenile)

Western Region Adolescent Services and it's medical/nursing vendor to provide routine and emergency medical and psychiatric care and treatment for the above-named juvenile. I also agree to pay for any medical, pharmaceutical and hospitalization charges that may be accrued for the above named juvenile.

_____
(Signature)

_____
(Date)

Please indicate any exceptions to this consent, including any non-prescription medication your child should not be allowed to take.

_____
_____
_____
_____
_____

Signed and dated form is valid for six months